DEVELOPMENT OF PHYSICIAN'S ASSISTANTS AND NURSE PRACTITIONERS IN CALIFORNIA*

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IN the fall of 1970 in the State of California there was signed into law a bill, AB 2109, which directed the Board of Medical Examiners to establish a new category, physician's assistants. This law was to have a great effect on the development of the concept of physician's assistants throughout the United States. The law had its genesis in the assumption that there was a huge shortage of health-care personnel–specifically physicians and nurses–and a flood of returning veterans who had acquired technical skills under military-medical auspices. What more logical solution than to hire these well-trained "medics" to work in civilian settings. The simplicity of this solution revealed an innocence about professional territorial imperatives and tradition-bound laws of licensure. This innocence would now seem incredible were it not for the continued appearance in the professional journals even today of articles which display similar naiveté. The physician's-assistant solution has turned out not to be a solution to the problem. It was instead an old-fashioned poultice, spread over an infection that for many years had been treated inadequately with soothing words and skin-colored Band-Aids.

The legislative bill sparked immediate and widespread activity. The Board of Medical Examiners elected to fulfill its legal charge to "consult . . . and seek advice" by holding public hearings in San Francisco in February and in Los Angeles in March of 1971 in order to hear testimony from *all* those who wished to participate in the decision-making process. Testimony was heard for four days. During the hearings it was

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made clear by the board that there would be no physician's assistants in California until regulations had been drawn up and approved methods of training had been established. There would be no "grandfathering."* There should be no unapproved programs for training physician's assistants, and no students should be recruited until programs had been approved for training. It was an historic four days. As the board well knew, there were several programs already funded for recruitment of students. There were also physicians who had hired ex-corpsmen to work for them with the expectation that well-qualified men *could* be "grandfathered" in. Letters had been received from a variety of sectors in the community proposing or opposing schemes for utilizing physician's assistants in a manner that in no way would have provided care of suitable quality to the citizens of the state. Appointments to the required Advisory Committee on Physician's Assistant Programs to the Board of Medical Examiners (ACPAP) were completed in March 1971. The first meeting was held in Sacramento on March 31, 1971. What followed was a full year of intensive deliberation.

The Board of Medical Examiners has a "judicial" regulatory function. It is responsible for adopting and enforcing the rules and regulations through which the Medical Practice Act is implemented. The responsibility of the board is to protect the interests of the public in the safe and proper practice of medicine.

The Advisory Committee was to define itself as a group of educators responsible for delineating the career of the physician's assistant in terms of educational requirements, supervision, duties, loci of work, and continuing education. The committee was charged also with the task of defining the preceptors and employers of these new health workers. Along with the board, it set itself the broader task of educating those who came before these agencies as to the intent and ramifications of AB 2109. Using a variety of educational methods, these two bodies tried to lead the various professional groups to a new understanding of their social functions and responsibilities.

The basic format of the new occupation, physician's assistant, was outlined in the first meetings of the Advisory Committee, with advice from the Board of Medical Examiners. Indeed a considerable portion of what developed in the regulations had been forecast in Forgotson et al.[1]

*Grandfathering is a traditional legislative device whereby previously existing practitioners are exempted from the requirements of a new, more restrictive licensing law.

It took much longer to arrive at a legitimized version which would gain the approval of interested parties and would clarify the reasoning that led up to these final decisions.

For example, the board early insisted that physician's assistants have the equivalent of an Associate Degree in Nursing as a prerequisite to their physician's assistant curriculum. It was the responsibility of the Advisory Committee to come up with a version of this content which would meet the requirements set by the Board of Medical Examiners while still differentiating between physician's assistants and registered nurses. Nurses were insisting upon this differentiation and one of the responsibilities of the Advisory Committee was to work for a consensus.

In their August and October meetings the Board of Medical Examiners considered various aspects of the problem of the physician's assistant and held formal hearings on the first regulations for physician's assistants in San Diego in November 1971. This hearing was attended by a large audience of physicians, nurses, educators, prospective physician's assistants, and members of the general public.

After this hearing the critical regulations governing physician's assistants in California were adopted. The sections on definition of supervision and on tasks performed by an assistant to the primary-care physician were extensive and explicit.

In the early days of the existence of the Advisory Committee and at the first hearings of the Board of Medical Examiners it was assumed that nurse practitioners might be included under the physician's-assistants bill. In this regard there was much opposition from some quarters and support from others. The ACPAP conceived its first duty to be the definition of the physician's assistant per se, and devoted its first year to that task. Once these regulations were adopted at the end of 1971, it became clear that nurses included in most nurse-practitioner programs were far more qualified academically in some areas than physician's assistants and were differently qualified in others. After a series of discussions and tentative remarks at public hearings during early 1972, the name of the ACPAP was changed by law in August of 1972 to the Advisory Committee on Physician's Assistants and Nurse Practitioner Programs. A licensed vocational nurse was added to the committee at this time. The renamed committee was to report to the Medical Board, the two nursing boards, and the legislature its findings on nurse practitioners.

The Advisory Committee completed its report in a formal public hearing before the Select Committee on Health Manpower on December 11, 1973. The report was approved by most sectors of the health-delivery system in the state. There were a number of minor concerns. The one major issue which united the various groups was their opposition to the proposal of the Advisory Committee that it be designated as an interim body to regulate nurse practitioners for three years. The Board of Medical Examiners claimed this right for itself. The Board of Nursing Education and Nurse Registration disagreed, pointing out that the nurse would still be a nurse. Other groups, such as the California Joint Practice Commission, had other opinions. There was little disagreement with the concept of the nurse practitioner, only with the implementation of regulations and education. Those most intimately associated with the development of the report felt that they had assisted in a successful delivery and christening. The fact that the relatives had immediately begun to squabble about whether the baby looked like great grandfather Hippocrates or aunt Florence was for the moment of little concern. Having lived through this argument themselves, the members of the Advisory Committee were happy to pass the problem along to the legislature. It should be noted that had this committee not already been a team when it undertook this responsibility, the outcome might not have been either as well-thought-out or as well-received as it was. The report had been cast in careful terms. It included vocational nurses in its definition of nurse practitioners. The relation between responsible physician and nurse practitioner was described with great care. The difference between physician's assistant and nurse practitioner was described as a matter of orientation.

At the time the present essay was being written, bills had been introduced in the legislature which dealt with a changed definition of basic nursing and nurse practitioners and with changes in the composition of the boards of nursing. The outcome of this process lies in the future.

What can be learned from this experience that would benefit other states? Some things seem clear. First, a crisis rules. A tendency toward "ad hocracy" conflicted with a feeling of destiny. The country was watching and the committee was torn between the goals of seeking immediate solutions and shaping a larger destiny. Most of the members had ties with national organizations that caused them to travel around the United States in the course of their professional activities. They were

well aware of the wider implications of their actions. When it became apparent, as it sometimes did, that other organizations of high rank were reaching similar conclusions, the members felt vindicated and eventually rather proud.

The pressures are different now and the committee is an experienced group. It seems fairly certain that having coped with the nurse-practitioner problem it will go back, review, and attempt to modify some of the earlier regulations. It now appears certain, for example, that the Supervision Clause and the Task List in the regulations concerning physician's assistants are too rigid, but these are the best decisions that could be fashioned in the climate that then prevailed.

Second, the process was made difficult by the relative isolation in which some of the decision-making proceeded. The committee would struggle through a problem and come up with a recommendation based on its own best judgment. The board, using a different frame of reference, met some of these recommendations unenthusiastically. The problem then arose of resolving these differences. The public—especially that section of concerned health practitioners not directly involved with the process—was to an amazing degree uninformed about what was happening. Meetings held in order to disseminate information were attended by large crowds. Some of the problems resulted not from lack of interest but from failure to understand how reliable information could be obtained. The committee and the board had expected that they would be allowed the traditional comparative privacy in which to carry on their deliberations. The few members of the public who persisted in attending those meetings were treated courteously, but often they merely saw people arguing about the contents of documents unavailable to the audience. Under such circumstances it was hard to understand what was going on.

There was also a failure to understand that, because the regulation of health-care providers is a social responsibility, the decisions regarding it must be reached by consensus—not only among the group preparing the regulations, but among the larger groups who must live by and be protected by these regulations. It is not enough to have the "right" answer. Everyone must have a chance to have his say—to air his own beliefs and prejudices and hurts. The decisions cannot be mandated. They must come from the wider group so that ultimately there is agreement that the solution derived is the best possible. At the beginning there

was much opposition to the board holding public hearings. Much later it became clear that this had been an essential element in the eventual success of the entire project.

With the deliberations concerning the nurse practitioner, the process was different. The public hearings by the committee were held in various places around the state and were well attended. A much greater effort was made to keep the concerned practitioners informed. When the final report was filed, it was received favorably because there had been wide involvement all along. People were more aware of the reasons behind the decisions and knew that they had had a part in shaping those decisions—whether successful or not.

There is a sometimes justified concern over the degree of public knowledge about the processes of government. It is easier and more efficient for a deliberative body to operate inconspicuously but the efficiency attained thereby is costly. It seems likely that a reliable "hot line" to which all rumors could be referred for verification or refutation would have been an economical investment over the long term. Broad publicity and a reputation for veracity would be essential ingredients in such an operation. The disadvantage of such a procedure would be that it might undermine the market for information and deprive many organizations of power now used to purchase favors and advantages. Some organizations and individuals apparently exist in a state of invincible ignorance; for them a hot line would have had no value, but it might have protected others with whom they dealt. The speed and endurance of untrue rumors was impressive. The less dramatic truths were not nearly so well distributed.

Third, there was no organized attempt to discover whether physician's assistants were needed in California. The law assumed a need. For a state under less pressure of outside events, a concerted effort to determine the need and the alternatives available for meeting it should most certainly be carried out. The Advisory Committee has come to believe that no student should be enrolled in a physician's-assistant program unless he has the prospect of employment. Experience with students who were graduated from unapproved programs where this factor was not taken into consideration reinforces and validates that belief. Further, the demonstration of need should be made in such a way that it can be certain that the need is an informed need. Those who consider hiring a physician's assistant must know exactly what a physician's assistant is

as well as what the rights and responsibilities of the employer are.

Fourth, the degree of ignorance observed among both physicians and nurses about the nature of their professional actions and the rights and responsibilities conferred therein is appalling. During these and other deliberations which were carried on concurrently it became abundantly clear that the average physician and nurse have little appreciation of what their licenses and the boards which are charged with enforcing them are all about. Decisions were made and are still being made by professional groups which betray, if not ignorance, at least a bland disregard for the functions of licensure and for professional disciplinary procedures. Given the history of licensure and disciplinary procedures in the United States (Derbyshire),[2] this may not be surprising but in the present day of space-age technology and consumerism it should not be tolerated.

Linked to this failure is another, the failure of many involved persons to understand the political process. Large groups of students and practitioners were misled by their organizations with unrealistic expectations about what the organizations could do for them. The displays engaged in by these organizations to demonstrate that the rights of their followers were being defended sometimes proved counterproductive. Skill, or at least a working knowledge of politics, is no longer a luxury for licensed occupations. It is essential.

Extrapolation of the California story to other states would have to be done with certain reservations, but with certain advantages. In California the process took place in an atmosphere of legal crisis. Earlier states had managed to circumvent, elude, or penetrate the legal thicket which protected the territorial rights of the medical profession. For California the time was ripe for confrontation. The problem of physician's assistants became the innocent rope in a tug of war. The battles fought were not those of mid-level health workers—they were the thinly disguised battles of several other wars. For physicians and nurses it was the erupting manifestation of a truce that had outlived its usefulness. For state and national professional organizations it was the continuing concern with states' rights versus national authority. For the medical-education establishment it was the right of the entrepreneur physician to train his own assistants versus the reputation of the educators and their assumed right to control the educational process. For the state and federal government it was the right to regulate social change with laws and

with money. The situation now is different and it will be different for each state which undertakes this process. The environment will be different. The other wars will have progressed to a different phase.

What were the strengths and weaknesses of the California process? Two strengths were especially notable: First was the early involvement of a wide variety of professional groups and governmental agencies. Second was the use of public hearings. A third strength, not related directly to physician's assistants but indirectly through the nurse practitioner, was the use of essentially the same group to study both occupational groups.

There were two notable weaknesses. First was the relation with the Board of Medical Examiners. With only one common member, busy separate schedules, and limited secretarial support, it was difficult to maintain adequate communciation between the two groups. Moreover, the group was hindered by previous patterns of decision-making. For example, it was difficult to find new ways of evaluating educational requirements. This difficulty is not surprising since this problem had not yet been dealt with effectively elsewhere in the nation. Since 1971 a good deal of money and effort has been expended in addressing educational equivalency. States that enter the arena can now start with a better technologic base.

Two pitfalls should be avoided. A committee with the responsibilities assigned to this one needs a statutory base with power to allocate funds, hire staff, and initiate studies. A blank check is not required, but some base is essential. Second, the establishment of rigid requirements for physician's assistants represented a conservative response to uncertainty. Since more experience has been gained, it should be possible for other states to benefit from that experience.

How can planning for alternative types of health workers best be translated into practical programs and coordinated? What was or should be the relation between planning for physician's assistants and planning for nurse practitioners? There was an early commitment on the part of the California government to avoid the further proliferation of licensing boards. A second early commitment was to the eventual development of an over-all Healing Arts Board. Six years of experience make it clear that limiting the number of licensing boards will be very difficult. Adequate supervision of a large profession requires much time. In California the boards are composed primarily of practitioners who devote full time

to other occupations. The work of the boards is unpaid except that expenses are reimbursed. The boards depend on a skilled staff. One logical way to handle new groups would be to establish joint membership on a liaison board between the medical and nursing boards. Not many citizens have the time and wealth to permit that kind of commitment. There is, however, some advantage to be gained by having the same group consider both physician's assistants and nurse practitioners. There are overlapping and separate skill areas and responsibilities which only become clear with familiarity with the boundaries of each. Many of the problems are related and require similar backgrounds on the part of the initial planners, but it is doubtful that they could be effectively considered completely, simultaneously. With one defined, it becomes a standard against which the second group can be more clearly delineated, and vice versa. There are overwhelming disadvantages which make such a group impossible to implement. There are, in California, extensive differences in preparation. There is also still a considerable emotional overlay connected with both of these groups and the parent disciplines from which they spring.

Finally, if there is to be one over-all principle which should shape the planning of any state, it should be quality care for the consumer. In our concern for upward and horizontal mobility, equal pay for equal work, full employment, and a brighter future for all, we sometimes lose sight of the social reasons for licensure. There is no doubt that licensure protects the licensee. It does this by differentiating for the consumer between those who are supposed to be qualified and those who are not. Whatever the hidden reasons for establishing regulatory legislation, the value to society must be apparent. Licensing laws must serve the public good. Where they do not, they must be changed or eliminated.

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